Michael S. Reilly, DDS
Family Dentistry

Child Registration Form

Today's Date:

Patient's Name (Last, First, Middle):

Nickname:

Date of Birth (month, day, year):

Sex (male, female):

Guardian's Name (Last, First, Middle):

Relationship to Patient:

Address (mailing address):

Home Phone:

Cell Phone:

Email:

Occupation:

Do you have any of the following diseases or problems:

Active Tuberculosis …….. YES/ NO
Persistent cough greater than a 3 week duration …… YES/ NO
Cough that produces blood …… YES/ NO
Been exposed to anyone with tuberculosis …… YES/ NO
(If you answer yes to any of the 4 items above, please stop and return this form to the receptionist)
Orthopedic total joint (hip, knee, elbow, finger) **replacement**? …… YES/ NO
Date: _____
(If you answered yes to the question above, please contact your physician in regards with taking antibiotic premedication before your dental visits)
Prosthetic cardiac valve …… YES/ NO
Previous endocarditis …… YES/ NO
Congenital heart disease …… YES/ NO
Cardiac transplantation recipients with cardiac valvular disease ……. YES/ NO
(AHA recommends that patients premedicate before dental treatments, if they have any of the 4 conditions listed above)
Please list the name and phone number of child's physician: …….....
……..

Insurance Information

Name of insurance policy:

Subscriber's name:

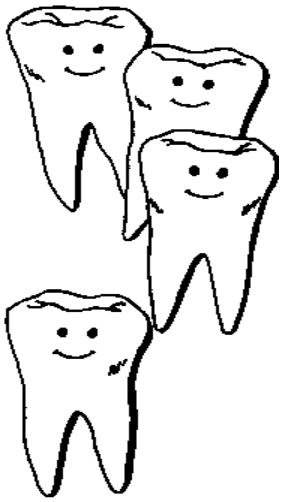
Subscriber's date of birth:

Subscriber's insurance number:

Subscriber's Group Number:

Health Information

Is the child taking any prescription and/or over the counter medications or vitamins at this time? .....
.....
Is the child allergic to any medications or foods? .....
.....
How would you describe the child's eating habits? .....
.....
Has the child ever had a serious illness or been hospitalized?
.....
.....
Does the child have any inherited problems? .....
Does the child have any speech difficulties? .....
Has the child ever had a blood transfusion? .....
Is the child physically, mentally or emotionally impaired?
.....
Has the child ever received a general anesthetic? .....
Does the child experience excessive bleeding when cut?
.....
Has the child had any problems with dental treatment in the past? .....
Has the child ever had dental X-rays before? .....
Has the child ever suffered any injuries to the mouth, head or teeth? .....
Has the child had any problems with the eruption or shedding of teeth? .....
Has the child had any orthodontic treatment? .....
Has the child had any endodontic treatment? .....
What type of water does the child drink (city water, well water, bottled water, filtered water)? .....
Does the child take fluoride supplements? .....
Is fluoride toothpaste used? .....
How many times are the child's teeth brushed per day and when are the teeth brushed? .....
.....
Does the child suck his/her thumb, finger or pacifier?
.....
At what age did the child stop bottle feeding? .....
Does the child participate in any active recreational activities and sports? .....



Do you have any concerns in regards with the child's oral health or esthetics?
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Note: Patients are encouraged to discuss any relevant health issues prior to treatment.
I certify that I have read and understand the above that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omission that I may have made in the completion of this form.
I understand that I will be responsible for any payments on my account. Payments are due on the day of the visit, unless you have made special arrangements with our office. I also understand that if I am unable to make my appointment, I will be responsible for providing the office with a 24-hour notice and any fees that may apply.

Signature Legal Guardian: Date: